Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
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Public Report

Report Issue Date: October 30, 2025
Inspection Number: 2025-1321-0007
Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: Fountain View Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21-24, 27-29, 2025
The inspection occurred offsite on the following date(s): October 30, 2025

The following intakes were inspected:

- Intake: #00154847 – related to a Follow-up of a Compliance Order (CO) regarding certification of nurses
- Intake #00159298 – related to Critical Incidents #2836-000026-25 and #2836-000027-25 regarding improper care of a resident
- Intakes: #00159996, #00160467 and #00160467 – complaints related to the improper care of a resident
- Intake: #00159748 – complaint related to the management of responsive behaviours

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1321-0005 related to O. Reg. 246/22, s. 51

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in the plan.

A Registered Nurse (RN) completed a treatment to a resident that was not in accordance with the physician's orders.

Sources: Video footage, a resident's clinical record including physician's orders and an interview with an Associate Director of Care (ADOC).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

An ADOC who had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in a risk of harm to a resident failed to report the suspicion to the Director.

An RN completed a treatment that was not in accordance with the physician's orders. An ADOC became aware of the incident but failed to report the suspicion to the Director.

Sources: Video footage and an interview with an ADOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that nursing staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

A Registered Practical Nurse (RPN) performed a procedure without performing hand hygiene before applying gloves, without cleaning a part of the device and without discarding their gloves after completion of the task.

Another RPN completed the same procedure without cleaning the same part of the device.

In addition, registered nursing staff were reusing and inappropriately storing devices.

Sources: Video footage, Home's Policy: Use of Gloves, IX-G-10.30 last revised March 2025 and interviews with the IPAC Lead, an ADOC and the Director of Care (DOC).